

IBEW Health and Welfare Trust of Southwest Washington Plan Amendments

IBEW PPO Plan

The I.B.E.W. HEALTH AND WELFARE TRUST OF SOUTHWEST WASHINGTON HEALTH CARE BENEFITS PLAN (the "Plan"), last restated effective July 1, 2009, is hereby amended as follows:

• **Plan Amendment #3**

Effective January 27, 2011 under **Eligibility Definitions** on page 2 of the Summary Plan Description, is amended as follows:

ELIGIBILITY DEFINITIONS

"Participant" means an employee or member who is qualified under the "Eligibility Rules" in Category I or Category II described on Page 5.

"Dependent" means any of the following individuals who are not otherwise eligible as Participants under this Plan:

1. The Participant's lawful spouse. A spouse may be eligible at the same time both as a dependent and as a Participant under this Plan.
2. The Participant's Domestic Partner, as defined in the section titled "Definitions" (refer to Page 72). An individual ceases to be a Domestic Partner when he or she no longer satisfies any of the requirements for Domestic Partner status in the Section called "Definitions."
3. Any natural child or adopted child of an eligible Participant, of the Participant's spouse or of the Participant's Domestic Partner who, at the time benefits are provided:
 - a. is less than 26 years of age; or
 - b. is less than 26 years of age; and
is an alternate recipient under an order determined by the Trustees to be a Qualified Medical Child Support Order.
 - c. coverage for a dependent child will terminate on the first day of the month following the month in which the dependent child reaches age 26.
 - d. is age 26 or older; and
is developmentally or physically disabled, and incapable of self-sustaining employment; and satisfies these two additional conditions:
 - the child was disabled prior to reaching age 26; and
 - proof of such developmental or physical disability, residence and support is provided within 31 days after the dependent reaches age 26 and subsequently thereafter as required. If the child's disability ceases for any reason, he or she will not thereafter be eligible for coverage under this provision.
 - e. Any dependent who was previously covered under this Plan, but whose coverage was terminated when they reached the age of 25. These dependent may re-enroll in the Plan if they are under the age of 26, contingent upon the Administrative Office's receipt of an enrollment form no later than June 30, 2011. Dependents that do not re-enroll during this special enrollment period will not be allowed to re-enroll in the Plan in the future (including yearly open enrollment).
- f. Any dependent child, with the exception of children of a Domestic partner, who reaches age 25 after January 27, 2011 will be allowed to continue on the Plan as a dependent until the first day of the month following the month in which they turn age 26.

Note regarding possible Tax Issues

If you enroll the children of your Domestic Partner, you may be responsible for paying income tax on the imputed income value of the benefits provided.

In addition, where a state law definition of a Dependent does not match with the federal law definition of a Dependent, your employer must include in your gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

You should consult with a tax specialist on these matters.

"Adopted child" means a child the Participant legally adopts, or who is placed for adoption with the Participant, before the child attains age 18. "Placed for adoption" means the Participant assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Provide Notice to the Administrative Office When a Child is No Longer a Dependent under the Plan. If the Participant's child ceases to be a Dependent within the meaning of the Plan, the child may be able to elect to continue his or her group health plan coverage for a limited period. This election is available only if the child or the Participant properly notifies the Administrative Office within a 60-day notice period. See the Section called "COBRA Continuation Coverage (Continuation of Only Medical, Dental and Vision Benefits)," refer to page 8.

NOTE: In order for a Dependent to be covered under the Plan, the Employee must also be enrolled in the Plan (except in the case of COBRA continuation coverage).

• **Plan Amendment #4**

Effective July 1, 2011 under **Eligibility Definitions** on page 2 of the Summary Plan Description, is amended as follows:

ELIGIBILITY DEFINITIONS

"Participant" means an employee or member who is qualified under the "Eligibility Rules" in Category I or Category II described on Page 5.

"Dependent" means any of the following individuals who are not otherwise eligible as Participants under this Plan:

1. The Participant's lawful spouse. A spouse may be eligible at the same time both as a dependent and as a Participant under this Plan.
2. The Participant's Domestic Partner, as defined in the section titled "Definitions" (refer to Page 72). An individual ceases to be a Domestic Partner when he or she no longer satisfies any of the requirements for Domestic Partner status in the Section called "Definitions."
3. Any natural child or adopted child of an eligible Participant, of the Participant's spouse or of the Participant's Domestic Partner who, at the time benefits are provided:
 - a. is less than 26 years of age; or
 - b. is less than 26 years of age; and
is an alternate recipient under an order determined by the Trustees to be a Qualified Medical Child Support Order.
 - c. coverage for a dependent child will terminate on the first day of the month following the month in which the dependent child reaches age 26.
 - d. is age 26 or older; and
is developmentally or physically disabled, and incapable of self-sustaining employment; and satisfies these two additional conditions:
 - the child was disabled prior to reaching age 26; and
 - proof of such developmental or physical disability, residence and support is provided within 31 days after the dependent reaches age 26 and subsequently thereafter as required. If the child's disability ceases for any reason, he or she will not thereafter be eligible for coverage under this provision.
 - e. Any dependent who was previously covered under this Plan, but whose coverage was terminated when they reached the age of 25. These dependents may re-enroll in the Plan if they are under the age of 26, contingent upon the Administrative Office's receipt of an enrollment form no later than June 30, 2011. Dependents that do not re-enroll during this special enrollment period will not be allowed to re-enroll in the Plan in the future (including yearly open enrollment).

Note regarding possible Tax Issues

If you enroll the children of your Domestic Partner, you may be responsible for paying income tax on the imputed income value of the benefits provided.

In addition, where a state law definition of a Dependent does not match with the federal law definition of a Dependent, your employer must include in your gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

You should consult with a tax specialist on these matters.

“Adopted child” means a child the Participant legally adopts, or who is placed for adoption with the Participant, before the child attains age 18. “Placed for adoption” means the Participant assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Provide Notice to the Administrative Office When a Child is No Longer a Dependent under the Plan. If the Participant’s child ceases to be a Dependent within the meaning of the Plan, the child may be able to elect to continue his or her group health plan coverage for a limited period. This election is available only if the child or the Participant properly notifies the Administrative Office within a 60-day notice period. See the Section called “COBRA Continuation Coverage (Continuation of Only Medical, Dental and Vision Benefits),” refer to page 8.

NOTE: In order for a Dependent to be covered under the Plan, the Employee must also be enrolled in the Plan (except in the case of COBRA continuation coverage).

- **Plan Amendment #5**

Effective July 1, 2011 under **Eligibility Medical Benefits Plan Option: Preferred Provider Plan** on page 44 of the Summary Plan Description, is amended as follows:

MAXIMUM BENEFITS

Lifetime Maximum Benefits are “unlimited”. Annual Maximum Benefits, if any, are as shown in the MEDICAL SUMMARY OF BENEFITS.

- **Plan Amendment #6**

Effective July 1, 2011 under **Medical Benefits Plan Option: Preferred Provider Plan Summary of Benefits** on page 42 and page 43 of the Summary Plan Description is also restated and is attached hereto:

Under **Prosthesis**, the benefit level is changed to \$30,000.00 per device.

Under **Preventative Care**, the \$300.00 limit as part of Routine Physicals is removed.

Under **Chemical Dependency Treatment**, the limitation of benefits to combined maximum benefit of \$12,500.00 per Calendar Year is removed.

Under **Durable Medical Equipment & Supplies**, the limitation of benefits to \$5,000.00 per Calendar Year is removed.

Under **Home Nursing and Therapeutic Services**, the limitation of benefits to \$1,500.00 per Calendar Year is removed and is now limited to 15 visits per calendar year.

Rehabilitation Services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under:

- Inpatient - 60 days per calendar year
- Outpatient 60 visits per calendar year

Under **Neurodevelopmental Therapy (to age 7)**, the 15 days per calendar year limit as part of Inpatient treatment is removed.

Under **Neurodevelopmental Therapy (to age 7)**, the \$500.00 per calendar year limit as part of Outpatient Assessment is removed.

Under **Neurodevelopmental Therapy (to age 7)**, the \$2,000.00 per calendar year limit as part of Outpatient Treatment is removed

Under **Physician Services**, the \$20.00 copayments as part of Preferred Provider Preventive Care are removed. Non-Preferred Provider Preventive Care is not covered.

Under **Emergency Room**, the 60% Coinsurance level for Non-Preferred Provider services is changed to match the Preferred Provider Coinsurance level of 80%.

Under **Urgent Care Center**, the 60% Coinsurance level for Non-Preferred Provider services is changed to match the Preferred Provider Coinsurance level of 80%.

• **Plan Amendment #7**

Effective July 1, 2011 under **Termination of Coverage** on page 15 of the Summary Plan Description is amended to reflect: a) removal of the paragraph under the numbered list in the "Participant Termination" provision; and b) insertion of a new permitted PPACA-compliant "Rescission of Coverage" provision below the "Dependent Termination" provision.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates, except as provided in any COBRA Continuation of Coverage Provision or FMLA:

1. On the last day of the month that the Participant ceases to meet the eligibility provisions of the Plan; or
2. On the date the Plan is terminated; or
3. On the date the Participant dies; or
4. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

DEPENDENT TERMINATION

Coverage for the Dependent of a Participant automatically terminates immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. the last day of the month in which the Dependent ceases to be an eligible Dependent (including when an individual ceases to be a Participant's Domestic Partner) as defined in the Plan; or
2. the date the Participant's coverage under the Plan terminates; or
3. the last day of the month in which the Participant ceases to meet the eligibility provisions of the Plan; or
4. the date the Plan is terminated; or
5. the later of i) the last day of the month following the date the Participant dies, or ii) in the case of a widow or widower, of a Participant who had a dollar bank, until the balance in the dollar bank is less than the amount of one month's current premium as described in the Section called "Benefits for Widows and Widowers." above; or

RESCISSION OF COVERAGE

A "rescission" is defined as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage under the Plan is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Two examples involving nonpayment of premiums where coverage may be canceled retroactively:

1. Retroactive terminations in the "normal course of business" are permissible.
2. Retroactive terminations for failure to notify the Plan when dependents covered by the Plan became ineligible.

The Plan is prohibited from rescinding coverage for individuals who are covered under the Plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice.

The Plan is required to provide at least thirty (30) days advance written notice to each individual who would be affected before coverage may be rescinded. This 30-day period will provide individuals with an opportunity to explore their rights to contest the rescission or look for alternative coverage, as appropriate.

Coverage will be canceled prospectively to correct errors in coverage, such as mistakenly covering a part-time Employee, but not by retroactively rescinding coverage, unless there was some fraud or intentional misrepresentation by the individual.

The Plan reserves the right to recover from the Employee and his covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on the part of the Employee, as determined by the Employer, continuation coverage under COBRA may be denied to the Employee and his covered dependents.

• **Plan Amendment #8**

Effective July 1, 2011 under **Pre-Existing Conditions Exclusion Rules: Preferred Provider Plan** on page 56 of the Summary Plan Description is amended to reflect the elimination of the pre-existing condition clause for enrollees under the age of 19:

EXCEPTION(S) TO THE PRE-EXISTING CONDITION WAITING PERIOD

1. Those persons continuously covered from the Effective Date of this Plan will not be subject to the Pre-Existing Condition Waiting Period. In addition, the Pre-Existing Condition Waiting Period will be waived for those individuals hired prior to the Effective Date of this Plan and continuously covered from their initial eligibility date.
2. The Pre-Existing Condition Exclusion does not apply to enrollees under the age of 19.
3. The Pre-Existing Condition Exclusion does not apply to a genetic predisposition to a disease or condition.
4. The Pre-Existing Condition Waiting Period does not apply to Pregnancy-related Covered Expenses.
5. The length of the Pre-Existing Condition Waiting Period may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan, provided there has not been a significant "break in coverage" between prior Creditable Coverage and the individual's Enrollment Date in this Plan. That is, so long as the person did not have a significant break in coverage (i.e., 365 or more consecutive days during which an individual does not have any Creditable Coverage), then one day from this Plan's Pre-Existing Condition Waiting Period will be subtracted for each day of Creditable Coverage from the other health plan. The Waiting Period does not count as a "break in coverage." All other Plan terms and limits still apply.

Thus, in order to determine the length of an eligible person's Pre-Existing Condition Waiting Period for purposes of this Plan, an eligible person will need to request a certificate of Creditable Coverage from his or her prior plan. The Claims Administrator will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan if he or she is experiencing difficulty in obtaining a certificate. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Condition Waiting Period imposed on that individual, that individual will be so notified.

• **Plan Amendment #9**

Effective July 1, 2011 the Summary Plan Description under **Eligibility** is amended to reflect the addition of the heading, **Gratuitous Dollar Bank Transfers** as follows:

Gratuitous Dollar Bank Transfers

Any Plan Participant who has a minimum reserve of three (3) months premiums in his/her dollar bank may transfer a maximum of \$500.00 per twelve (12) month period to another Plan Participant's dollar bank. The recipient of this Gratuitous Dollar Bank Transfer must have continuous coverage under the Plan for the previous twelve (12) months prior to receiving this donation.

Recipients of these donations are limited to no more than twelve (12) months of continuation of coverage using these Gratuitous Dollar Bank Transfers during the lifetime of the individual. COBRA coverage would apply after any extensions per these transfers, and COBRA would be subject to standard premium payment (not subject to Dollar bank credits of any kind).

Participants who make Gratuitous Dollar Bank Transfers must do so in writing to the Administrative Office. Requests must include the full name and Social Security Number of the Participant making the donation and the recipient of the transfer and the signature of the Participant making the donation must be witnessed by a notary public. Gratuitous Dollar Bank Transfers will be posted to the recipient's Dollar Bank the first day of the month following the receipt of the request.

● **Plan Amendment #10**

Effective July 1, 2011 the Summary Plan Description under **Benefits Provided by the Preferred Provider Medical Plan Option** is amended to reflect changes at "II. Preventive Care" under the section titled "Covered Services" as follows:

II. **Preventive Care Services**

Preventive care services are provided under the Plan as outlined in the Medical Summary of Benefits. Preventive care services or items include those recommended by the U. S. Preventive Services Task Force (with an "A" or "B" rating), immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention, and preventive care and screenings for children and for women as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA").

Based on the Covered Person's age, gender and risk factors, these services include, but are not limited to:

- Routine screenings for blood pressure, colorectal cancer, cholesterol, depression, diabetes, certain sexually transmitted diseases, tobacco use, alcohol misuse, alcohol and drug use, and recommended immunizations (based on age and population).
- Additional screenings for women include anemia, cervical cancer, Chlamydia infection, hepatitis B, osteoporosis, rh incompatibility, bacteriuria urinary tract, mammography, and chemoprevention. Additional services, including counseling and drug therapies for certain conditions, are also covered for patients at risk for certain diseases based on age or other lifestyle factors.
- Preventive services for children include, but are not limited to, autism screening, behavioral assessments, various screenings for newborns, developmental screening, hematocrit or hemoglobin screening, vision screening, oral health assessment, vision screening, height/weight/body mass index evaluations, and recommended immunization vaccines through age 18 (based on age and population). Additional services, including counseling and other supplements are also covered for children at a higher risk for certain conditions such as anemia, lipid disorders, Fluoride deficiency, lead exposure, obesity, or tuberculosis.

To find out if a particular service meets the recommended guidelines as preventive care, visit:

<http://www.healthcare.gov/law/about/provisions/services/lists.html>.

● **Plan Amendment #11**

Effective July 1, 2011 the Summary Plan Description under **Claims and Appeals Procedures: Preferred Provider Plan** is amended to revise the time requirement to review urgent care claims and to insert the following new provision—as required by the Patient Protection and Affordable Care Act—at the end of the section.

INDEPENDENT EXTERNAL REVIEW

A Covered Person may have the right to have his case reviewed by an external independent review organization. Only decisions that are based on issues related to Medical Necessity, medical appropriateness, health care setting, level of care, or effectiveness of a covered benefit may be appealed to an external independent review organization. The Plan must contract with at least three (3) different independent external review organizations and must rotate between them on a random or circulating basis.

Independent external review is available and may be subject to a minimal cost to the Covered Person of up to \$25 (which will be returned if the independent review organization rules in the Covered Person's favor). The request for an independent review must be made within four (4) months of the date of the final internal adverse claim determination.

A final decision made by an independent review organization is binding on the Plan. This decision is also binding on the Covered Person, except to the extent other remedies are available under state or federal law.

In certain instances the Covered Person may be able to request an expedited review process, such as when the timeframe for completion of the internal appeals process would seriously jeopardize the life or health of the claimant or their ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the claimant received Emergency services, but has not been discharged from a facility.

• **Plan Amendment #12**

Effective July 1, 2011 the Summary Plan Description under **Benefits Provided by the Preferred Provider Medical Plan** is amended to:

- a) insert the following provision as new item L. in subpart "XI. Other Benefits", as requested by the Transplant Policy insurer; and

XI. Other Benefits..

L. Organ & Tissue Transplant Benefits

Human organ and tissue transplant benefits are provided according to the terms and conditions set forth in a separate Organ & Tissue Transplant Policy (Transplant Policy) that has been issued to this Health Care Benefits Plan. Transplant related benefits will be provided to each Covered Person during the transplant benefit period specified in the Transplant Policy. Once the transplant benefit period has elapsed and/or transplant benefit maximum has been reached, all transplant-related benefits will revert back to this Health Care Benefits Plan, subject to its terms and conditions. See Appendix B, later in this Document.

Transplant related benefits are only available to individuals who:

- A. Are eligible for medical benefits under this Health Care Benefits Plan; and
- B. Meet all the terms and conditions outlined in the Transplant Policy; and
- C. Have fulfilled the Pre-Existing Condition Waiting Period (if applicable) as defined in the Transplant Policy.

Covered Persons who are subject to a Pre-Existing Condition Waiting Period under the Transplant Policy may be eligible to receive transplant benefits according to the terms and conditions of this Health Care Benefits Plan subject to the Pre-Existing Condition Waiting Period of this Plan. See Appendix B, later in this Document.

This fully insured organ transplant coverage is not subject to the requirements of Health Care Reform. Please be advised that any pre-existing limitation that would be applicable to Plan Participants on the self-funded Medical/Rx coverage will be maintained in relation to organ transplants, along with any annual and/or lifetime maximums as provided on either or both policies.

- b) modify Medical Plan Limitations and Exclusions item. 49, as requested by the Transplant Policy insurer; and
49. Charges related to transplants, except Cornea Transplants, as specifically stated. However, Organ and Tissue Transplant Benefits are provided under the separate ~~AIG Life Insurance Company~~ Comprehensive Transplant Insurance Policy, administered by Medical Excess, a member company of AIU Holdings, Inc. See Appendix A in this Document. Please also refer to the Certificate of Coverage provided by AIG Life Insurance Company (available upon request through the Administrative Office for all eligibility, benefits, Limitations and Exclusions;
- c) replace the previous "Appendix A" and insert the newly revised "Appendix A", as requested by the Transplant Policy insurer; and

APPENDIX A: MEDICAL EXCESS COMPREHENSIVE TRANSPLANT BENEFIT PROGRAM

IBEW of Southwest Washington has included an Organ & Tissue Transplant Program as part of your medical benefits package. This program is administered by Medical Excess, a member company of AIU Holdings, Inc.

This section is designed to assist in understanding the Transplant program. **However, please refer to the Organ & Tissue Transplant Policy and Certificate of Coverage for complete coverage details, including applicable Benefits, Limitations, and Exclusions.** (Policy Form Number: M20001) A copy of the Policy and Certificate of Coverage may be obtained by contacting the Administrative Office.

Overview of Benefits

- \$1 million lifetime maximum for the following transplant types:

Heart	Lung	Heart / Lung
Bone Marrow*	Stem Cell*	Liver
Kidney	Pancreas	Kidney / Pancreas
Small Intestine		
- Benefit Period that begins at the time of evaluation and ends the sooner of 365 days after the transplant procedure or the lifetime maximum has been met under the Transplant Policy.
- Specialty Care Center Network transplant providers—100% coverage for all transplant-related expenses, including certain drugs after transplant
- Non-Network transplant providers—80% coverage, subject to a specified amount and 20% Copay
- \$10,000 travel; lodging and meals reimbursement maximum for patient and one (1) companion.

All transplant services (including evaluation, listing and transplant) are subject to Medical Excess' medical review and prior approval.

* Coverage for adults is for National Cancer Institute (NCI) sponsored Phase III or higher clinical trials only.

* Coverage for children is for NCI or Children's Oncology Group sponsored Phases I, II, III and IV clinical trials

Transplant benefits are those expenses that are transplant-related. Other non-transplant related expenses will be paid in accordance with the terms and conditions of the Company's Medical Plan. Non-transplant related expenses include, but are not limited to the treatment of underlying disease or unrelated conditions. Transplant Policy provisions are subject to eligibility and Pre-Existing Condition Limitations**.

Note: If you are covered under a high deductible health plan (as defined by the IRS), you will be required to meet that deductible before benefits will be eligible under the Transplant Policy. This requirement is necessary so that you qualify for the tax benefits associated with your high deductible health plan and related health savings account, if applicable.

What Happens if a Transplant Operation is Needed?

A Physician may recommend a transplant operation for the Employee and/or his Family member. Many transplant operations are successfully performed every day in America, and can provide a longer and healthier life outcome. There are nearly 40,000 solid organ and bone marrow transplant operations performed each year in over 250 qualified transplant centers across the country.

Despite the significant medical and technological advances of the past few years, transplant operations remain one of the most costly surgical procedures to be performed. This Transplant Program has been designed to help deliver excellent and uncompromising care. To help the Covered Person attain the most complete coverage, two simple steps should be undertaken:

1. Once the Physician has diagnosed the Covered Person as a possible transplant candidate, **Trusteed Plans Service Corporation (TPSC) must immediately be informed, phone (800) 426-9786 ext. 210.** Failure to comply with this step could result in a loss of full coverage.
2. Refer to the Certificate of Coverage (available by contacting Administrative Office) to understand benefits as they relate to organ and tissue transplants. If there is a question, please contact **Trusteed Plans.**

What Happens Next?

Once TPSC has been informed and the Physician has been consulted, the Covered Person will be assigned a Transplant Nurse Advisor. In addition, the Transplant Nurse Advisor will help the Covered Person and his Physician to identify an appropriate transplant center. The coverage increases when the Covered Person and his Physician choose a transplant center in the Specialty Care Center Network® (SCCN). Any transplant-related services including consultation should not be obtained until approved by the Transplant Nurse Advisor.

The Transplant Nurse Advisor will also assist during the entire covered "episode of care". There are essentially four phases to a transplant episode of care:

Evaluation: This is when the Covered Person first visits with the transplant surgeon. The Covered Person will be examined and tested to determine if he qualifies for a transplant. The Covered Person will also meet with other members of the transplant team who will assist in the decision-making process. The transplant center will assign a

Transplant Coordinator. The Transplant Coordinator and the Transplant Nurse Advisor will work together to assist the Covered Person throughout your transplant process.

Candidacy: Once the Covered Person is determined to be a good candidate for an organ transplant, the Covered Person's name is placed on the United Network of Organ Sharing (UNOS) waiting list. If a bone marrow transplant requires a donor, the transplant team will search the National Marrow Donor Program (NMDP) donor database. Many factors will determine how long the Covered Person's will have to wait for an available organ—such as medical status, the availability of donors in the local area and the level of match between the donor and recipient.

Procedure: This relates to the Covered Person's actual transplant and Hospital stay. How long the Covered Person will need to stay in the Hospital varies for the different types of transplant procedures. The Transplant Nurse Advisor will work closely with the transplant team in planning the Covered Person's discharge needs and follow up care

Follow Up: Once the Covered Person has been successfully transplanted and released, he will be monitored closely by the transplant team; focusing on status of health, diet exercise and the necessary anti-rejection drugs. This period of time generally lasts for a year after the surgery.

What Can You Do To Make It Easier For You?

As mentioned earlier in this section, the Covered Person must notify TPSC if a transplant operation is needed. After this, the Covered Person should not proceed with any transplant-related services (including consultation, evaluation or listing) until services have been approved by the Transplant Nurse Advisor. The Covered Person must also make sure that he has carefully studied and understands what the benefits are in this situation, such as reimbursement for travel, lodging expenses, and other costs. All receipts relating to the transplant expenses should be saved. Do not be afraid to ask questions if they develop. The Transplant Nurse Advisor is also a good source for answers.

There are many support groups and organizations for transplant patients to share their concerns, as well as resources for researching issues concerning a transplant operation. A good place to start is the Internet. The United Network of Organ Sharing (UNOS) and the National Marrow Donor Program (NMDP) have highly informative web sites (www.unos.org and www.marrow.org) to address many concerns. They may also suggest other informative web sites.

We understand that this is a critical and uncertain period of time in each patient's life. At times, there is confusion and worry. The Transplant Nurse Advisor is highly experienced in understanding all the issues, and is available for each patient. All efforts will be made to assist each patient successfully through this process. Remember, many thousands of people have had successful transplants and are leading productive and happy lives today.

For further information on a Covered Person's health coverage, call TPSC at (800) 426-9786 ext. 210 or the Medical Excess Transplant Unit at (800) 850-0919.

Once the transplant benefit period has elapsed OR the transplant maximum benefit has been reached under this “Medical Excess Comprehensive Transplant Benefit Program”, transplant-related benefits will revert back to the Company Health Care Benefits Plan, subject to its terms and conditions. See Appendix B.

d) **insert, immediately following “Appendix A”, new “Appendix B”. APPENDIX B: IBEW HEALTH CARE BENEFITS PLAN'S TRANSPLANT BENEFIT**

XI. Transplant Benefit

All transplants must be pre-authorized; that is, the Plan conditions receipt of transplant benefits on approval of the benefit in advance of obtaining medical care. Services and supplies in connection with transplant procedures are covered, subject to the following conditions:

- A. Only human tissue-to-tissue transplants will be considered as eligible for coverage under the Plan. The following transplant procedures will be considered as covered: cornea, heart, heart/lung combined, islet cell, kidney, kidney/pancreas combined, liver, lungs (single/bilateral/lobar), small bowel and small bowel/liver. All other transplant procedures, including Experimental and/or Investigational, non-human organ or artificial organ Implant procedures, are specifically excluded. No benefits will be provided for transplant of a lung or other organ (except kidney) from a living donor unless such donor has been declared brain dead by the attending provider.
- B. Allogenic (related or unrelated) bone marrow transplants will be provided, limited to the following malignancies or conditions: acute leukemias (lymphocytic or non-lymphocytic), chronic myelogenous leukemia, aplastic anemia, lymphoma (Hodgkin and Non-Hodgkin), neuroblastoma stage III and IV in children over one year of age, or multiple myeloma.

Autologous (self-donor) bone marrow transplants or stem cell support will be provided, limited to the following malignancies or conditions: Lymphoma (Hodgkin or Non-Hodgkin), neuroblastoma, acute leukemias (lymphocytic or non-lymphocytic) or multiple myeloma. Bone marrow transplants and stem cell support for other conditions will not be covered.

Services and supplies related to removal and treatment of the bone marrow and the hospitalization from the day of bone marrow infusion until the patient is discharged will be applied toward the benefit maximum.

- C. In addition, a second opinion must be obtained and submitted to the Claims Administrator for pre-authorization prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
- D. If the donor is covered under this Plan, Covered Expenses Incurred by the donor will be eligible for benefits. If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person will be treated separately for each person.
- E. If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be eligible for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to Participant eligibility requirements, will be considered Covered Expenses, to the extent that such expenses are not payable by the donor's plan, up to \$20,000 per transplant. Any donor benefit will be charged against the recipient's benefit maximum.
- F. Benefits for procurement of the donor organ or bone marrow are covered, up to donor maximum benefit of \$20,000. The Plan will cover the evaluation of the donor organ or bone marrow, its removal, and transport for both the surgical/harvesting team and donor organ and bone marrow. Also covered are bone marrow testing and typing of the brothers, sisters, parents, and children of the recipient. Testing and typing of any other potential donor is not covered.

The transplant benefit does not cover:

- A. Transplants until the individual has been covered by this Plan for twelve (12) consecutive months, whether or not the condition is a Pre-Existing Condition or an Emergency.
- B. Services received from a non-preferred facility, unless there is no preferred facility that is able to render the necessary treatment. If this is the case, documentation must be provided and is subject to approval of the Claims Administrator (TPSC). Benefits will be paid as if a preferred facility had been used.
- C. Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- D. Donor costs for a transplant that is not covered under this benefit or if the recipient is not a Covered Person under the Plan. However, complications and unforeseen effects from a Covered Person's organ or bone marrow donation will be covered under this Plan as any other illness.
- E. Organ or bone marrow search or selection costs (including registry charges), except as provided under donor costs.
- F. Meals, lodging and transport, except as provided for transportation of the surgical/harvesting team and donor organ or bone marrow.

● **Plan Amendment #13**

Effective July 1, 2011 under **Medical Plan Limitations and Exclusions: Preferred Provider Plan** on page 53 of the Summary Plan Description is amended to reflect the elimination of hidden pre-existing conditions as follows:

- 8. Charges Incurred in connection with the care or treatment of, or surgery and its complications performed for a Cosmetic Procedure unless Medically Necessary:
 - a) Due to an Injury while.
 - b) For correction of congenital deformity in a child. To be covered, the surgery must be done within six (6) years of the date of birth applied without respect to when the individual is enrolled in the

- Plan.
- c) For reconstructive surgery as necessary for the prompt treatment of a diseased condition while covered under this Plan or the prior Trust-sponsored plan (unless otherwise required by applicable law).
- d) By reconstructive breast surgery that is in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit of this Plan.
16. Services, supplies or charges: a) that are directly related to the care, filling, removal or replacement of teeth; and b) the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. However, benefits will be payable for treatment required because of accidental bodily Injury to teeth. Treatment must begin within 12 months of the accident causing the Injury. This exception shall not in any event be deemed to include charges for a biting or chewing injury or treatment for the repair or replacement of a denture;

• **Plan Amendment #14**

Effective July 1, 2011 under the **Preferred Provider Plan Summary of Benefits** on page 42, is amended as follows:

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATION	Services from non-Preferred Providers are limited to the Allowed Charge	
OUT-OF-POCKET MAXIMUM	100% payment when an individual's out-of-pocket expense for allowable Coinsurance reaches \$5,000 in a Calendar Year (\$15,000 per Family). Deductibles, Copays, Outpatient Prescription Drug Copays, Mental Health services and services from non-Preferred Providers do not apply to the out-of-pocket maximum and do not increase to the 100% benefit level.	
ANNUAL MAXIMUM BENEFIT	\$1,000,000	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
DEDUCTIBLE — <i>Deductible Waived for services subject to \$20 Copay, Outpatient Prescription Drugs and for covered services received on the day of or within two days of an accidental injury.</i>	\$500 per person, per Calendar Year \$1,500 maximum per Family	

Refer to the appropriate Summary Plan Description for limitations and/or exclusions.